PRINTED: 12/20/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN				C 2/2007
	OVIDER OR SUPPLIER		•	100	ET ADDRESS, CITY, STATE, ZIP CODE 0 S STERLING ST PRGANTON, NC 28655		
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A 000	INITIAL COMMENTS	S	Α	000			
	conducted from 07/3 allegation that the ho safety of a patient du record review of Patie was manually restrain the dining room on 02 1210. Record review became unconscious respirations present a which time the manual Record review reveal and CPR was initiate revealed the patient of the safety of	and had no pulse or at approximately 1215, at al restraint was released. led a Code Blue was called d at 1215. Record review was transferred to an acute at 1235, with resuscitative s, where he was nced dead.					
A 006	immediate jeopardy (safety beginning on 0 manual restraint occudiscussed with the ac 08/02/07 at 1230. The developed and immeraction plan to correct was not removed. 482.12 GOVERNING. The hospital must habody legally responsion hospital as an institut have an organized go legally responsible for	IJ) to patients 'health and D2/01/07 at 1210, when the curred. The findings were diministrative staff on the administrative staff diately implemented an the deficiencies. The IJ BODY We an effective governing ble for the conduct of the hospital that inctions specified in this part	Α	006			8/10/07
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	=		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST ORGANTON, NC 28655			
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A 006	Continued From page	e 1	A 006				
	Based on hospital poreviews, closed media investigative report reand staff interviews the failed to assure effect ensure the safe applic of a patient on the floother findings include: 1. The hospital failed procedure for the safe restraint of a patient of the safe restraint of the safe restraint of the safe restraint of the safe restraint of the safe restraints. - Cross refer to 482. A0038 5. The hospital failed supervised by nursing competent in the use continuous monitoring status and restraint to manually restrained process.	to have a policy or e and appropriate manual on the floor. failed to continuously atus of a patient for 1 of 2 straints reviewed (#2). I to implement safe restraint patients in manual restraints I to ensure staff were trained application of manual 13 Patient Rights, Tag I to ensure a patient was g staff that were trained and of restraints, including g of the patient's health					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 006	Continued From page	e 2	A 006			
A 038	A0199 482.13 PATIENTS' R	RIGHTS	A 038		8/10/07	
	A hospital must prote each patient.	ect and promote the rights of				
	Based on hospital por reviews, closed medi investigative report reand staff interviews to	not met as evidenced by: licy and training manual cal record reviews, hospital eview, personnel file reviews he hospital failed to protect in manual restraints on the				
	The findings include:					
	The hospital failed procedure for the saf restraint of a patient.	e and appropriate manual				
	~ Cross refer to 482. Tag A0814	13 [e][4][ii] Patient Rights,				
	monitor the health sta	failed to continuously atus of a patient for 1 of 2 straints reviewed (#2).				
	~ Cross refer to 482. A0822	13 [e][10] Patient Rights, Tag				
		d to implement safe restraint patients in manual restraints				
	~ Cross refer to 482. A0835	13 [f] Patient Rights, Tag				
	4. The hospital failed	d to ensure staff were trained				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN				C 2/2007
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BROUGH	TON HOSP			l	000 S STERLING ST MORGANTON, NC 28655		
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A 038	and competent in the restraints.	e 3 application of manual 13 [f][1] Patient Rights, Tag	A	038			
A 199	482.23 NURSING SE	ve an organized nursing 24-hour nursing services. must be furnished or	A	199			8/10/07
	Based on hospital police reviews, closed medicinvestigative report reand staff interviews the supervision by a regisuse of manual restrain	not met as evidenced by: licy and training manual cal record reviews, hospital eview, personnel file reviews ne hospital failed to provide stered nurse trained in the nts of a patient lying on the is in manual restraints on the					
	competent in the use continuous monitoring status and restraint to manually restrained p	g staff that were trained and of restraints, including g of the patient's health					
A 204	Tag A0204	PERVISION OF NURSING	A	204			8/10/07
	A registered nurse m	ust supervise and evaluate					

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A 204	Based on hospital pol reviews, closed medic investigative report re and staff interviews the patient was supervised trained in the use of n	not met as evidenced by: icy and training manual cal record reviews, hospital eview, personnel file reviews he hospital failed to ensure a d by nursing staff that were hanual restraints of a patient continuous monitoring of for 1 of 2 manually	A 2	204			
	Restrictive Intervention revealed, "Policy: Issumanual restraint and/ used only on an emerophysical techniquintervention in the material propossible, verbal or en non-physical techniquintervention in the material propossion is made for conditions in areas us continuously observe emergency restrictive Competency-based to of the use of these proposed in the provision is made for conditions in areas us continuously observe emergency restrictive Competency-based to of the use of these proposed in the proposed	polation time-out, seclusion, or psychiatric restraint are regency basis to terminate a which a patient is in jury to self or others or perty damage is occurring. If vironmental change (i.e. les) is the preferred in agement of behavior. humane, secure, and safe sed. Patients are diduring use of all					

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A 204	patient's freedom of rephysically resistive patherapeutic hold/carry restricts his or her morestraint for that patie therapeutic holds/carry Carolina Intervention emergency, by staff was of manual restraitime is not sanctioned utilized, the patient's breathing, signs of phoduring implementation Emergency Restrictiv NoteImplementation Interventions:D. Rhas notified, conducts which includes:b. Crespiratory/cardiac disof any distress prompassessment of vital sicontinues:b. Assignmonitor the patient Progress Note:(5) Han. R" Review reinstructions for the month of the floor. Review of "North Cardated 03/31/03 revearemember that the imprestrictive intervention the person is reshould insure that the intervention. They are apparent circulation parents in the patient of the parents of the person is reshould insure that the intervention. They are apparent circulation parents in the patient	anner which restricts the movement. 1. Holding a atient in an approved //walk or other manner that ovements constitutes manual antThis includes ries that are approved North (NCI) techniques during an who are NCI-certified. The nt for any extended period of d. 2. When Man. R is health status (adequate hysical distress) is assessed in and is documented on the re Intervention Progress on of Emergency Restrictive N Responsibility: 1. As soon a health status assessment observing/assessing for stress (clinical assessment observing/assessing for stress (clinical assessment observing of the ERI dealth status monitoring for evealed no documentation of anual restraint of a patient olina Intervention" manual alled, "It is important to mediate goal of the is to insure the safety of in the surrounding area. Estrained, staff involved a person is safe within the ebreathing freely, no	A	204			

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	ROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE		
	1			IV	ORGANTON, NC 28655		
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A 204	therapeutic holds and Review revealed no of for the manual restrail Medical record review patient was admitted schizophrenia and die the physician's discha 02/23/07 revealed, "(I admitted grossly psychiatric care The was characterized by including inappropriat patient was initiated antipsychotic medicar Over the course of (Patient's name) show He stopped making s and became much mhis own personal self He was still, even on death, very disorganiz questions with nonseable to sit still, which was able to respond appropriately, which was able to respond appropriately. Throughout his stant the dining room at death). He appeared which he had done be redirection. In the pa	al techniques as well as I transport techniques. I transport techniques and the foot of a patient with a long transport of a transport of	A	204	DEFICIENCY)		
	especially lately, had general. This time, for	st a few staff members and been more redirectable in or reasons still unknown to ely irate, intensely agitated,					

Facility ID: 956125

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		I	C)2/2007
	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
A 204	harm to peers and to manually restrained a restraint, he apparent cardiac event and de the scene, as well as expired" Medical record review B (a nursing assistant (denoted as "late ent said 'He was still hun Pt was trying to get may serve food from the was effective @ that table to sit down, he sof mayo. Pt. said 'I a took mayo from the ptook food out of trash Pt. was redirected infollowing pt. Pt. turns another trashcan. Mr. (Emergency Transmi grabbed pt. then staff tried to kick, bite staff his name. Staff calle got first aid kit such a for CPR." Medical record review L (a nursing assistant (denoted as "late ent Staff L) walked in, from Everything was ok as by. As ptstood up mayonnaise I and (Si mayo pr would not ha grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the grabbed his hands and side the staff beautiful to the st	rashcans around, threatening staff. Subsequently, he was and in the context of that the suffered some kind of spite provision of CPR on rapid response of EMS, he of documentation by Staff the dated 02/01/07 at 1307 ray") revealed, "pt. (patient) gry'; after eating his lunch. The food from the ladies that window. Pt was redirected, it time. Pt. started going to his stopped and got five packs in going to eat them' staff the trip. The then walked around, can and started eating it. The effective staff stopped ed trashcan over picked up rediation was called and ET resion) button was hit. Staff for lowered pt. to ground pt. The form the ladies of the staff stopped provided the staff stopped and got five packs and started eating it. The sision was called and ET resion) button was hit. Staff for the staff stopped provided the s	A 204			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 204	food. Pt. was very ar can and threw it towa (Staff A), grabbed pt a help. We finally got pfighting to get up, pt sminutes pt seemed to gradually let go but pt so a staff member cal stared CPR. I held tharm, (Staff J) held rigi and (Staff A) on top. could not see pts face assistant) arms or ham. Medical record review (a nursing assistant) (denoted as "late entroame in and took him top of (Patient's name name)'s face at all. I name)'s right arm howon the right leg. (Staft L) had his left arm howas violently strugglir After several minutes nurse asked someone The medical team can get up and return to medical record review M (a registered nurse 1300 (denoted as "lata approximately 1210 pwas placed in MR (mastaff, I then assisted (Staff I) and (Staff J) were holding pt's L (leapproximately 1211.	rgry. Pt. picked up the trash rds staff. A staff member as other staff approached to it on the ground. Pt. was still angry. After a few have calmed down so we wasn't moving or breathing led the code while (Staff F) is left arm, (Staff I) held right in teg, (Staff D) held left leg, (Staff A)'s back facing me is or the CNA (nursing inds." If of documentation by Staff J dated 02/01/07 at 1345 y") revealed, "(Staff A) down, I seen (Staff A) on it is could not see (Patient's indicate (Staff I) on (Patient's indicate I) in the left. (Staff I) in the left. (Staff I) in the left in the le	A	204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
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	ROVIDER OR SUPPLIER		100	ET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST DRGANTON, NC 28655			
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A 204	RN and (Staff F) LPN arrived to assist, at appecame unresponsive Medical record review (a nursing assistant) (denoted as "late entr#2) grabbed trash carthat time we grabbed floor. I had his right a + (Staff D) had his left had his right legg hold laying across left side across his back. We him to restraint room Someone asked if we (intramuscular injection nurse was bring it. (Sigive the shot when it Pt went relaxed and (and breathing. (Staff deep breaths and the (Staff C) started CPR called" Medical record review C (a RN) dated 02/01 "late entry") revealed dining room patient in was 1210. Patient in of five minutes from member (Staff A) who (Staff A) was repeate on him in which his re (Staff N) attempted to possible PRN (as needs to see the second in the possible PRN (as needs to see the second in the possible PRN (as needs to see the second in the possible PRN (as needs to see the second in the possible PRN (as needs to see the possible prediction in the predicti	(licensed practical nurse) oproximately 1215 pt e. (Staff N) called code" of documentation by Staff I dated 02/01/07 at 1310 cy") revealed, "he (Patient of and threw it at staff. At pt and rolled him to the arm holding it down, (Staff L) to legg holding it and (Staff J) ding it down. (Staff A) was e of Pt chest with his left arm tried letting Pt up to take but Pt start kicking again.	A 204				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 204	back @ manual restraside of the patient and At 1215 patient non restimulation. (Staff N) to get back from patie or pulse present. Stathis writer's request Review of documentathospital's investigative dated 02/01/07 at 133 into dining room p (af Staff had the pt. in the and growling at staff. to the kitchen and cale (Physician's Name) as had stated that the newalked to the patient' concerned his eyes we protruded slightly c (versame time that (Staff hand on his (pts.) new told him not to do that said twice. Some state background 'he will site breathing. 2 or 3 of the report revealed document by Staff N dated 02/00 "late entry"). Review Staff N revealed, "He team) called to (F1) of Upon arrival 2 RN's at Hold. RN's stated pt. out of the dining room operator. Pt. was grostaff. Requested operators.	cal distress. (Staff N) arrived aint. This writer was to the d (Staff N) @ patient's head. esponsive to verbal or tactile and this writer told (Staff A) ent. No respirations present off member called 2121 @" ation available in the ereport by Staff N (a RN) as revealed, "1212 I walked fer) care team was called. e floor. He was screaming I walked to the door going alled for the operator to page to 1213. I walked back staff curses were out side. I series and became were closed and his tounge with) blue tint. I note at the A's name) had his R (right) ck Firmly and took his hand to 'get off his chest' I	A 204			

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A 204	closed and tounge was blueish tint. Instructed Attempted to obtain repreath sounds. None Review of documentate hospital's investigative assistant) dated 02/0 (patient) threw the capts and staff safe I write other under his lein front. I was unable thought if I just hange least slow him down, directions trying to grassomeone got hold of down to get him to go pt starting to go to the hold to slide around it was going to go down same hold on the flood on my right chest. Pt at same time was trying and bite me that his elooked as if they were being held by many shad a real hard aggret to bite Pt looked as if got off him. At this poand had no response team." Interview with Staff C revealed during the monthe floor of the din and Staff M (the othe	assessed his face eyes were as protruded slightly c (with) d staff to stop NCI. esponse, or pulse, and e noted began CPR" ation available in the ereport by Staff A (a nursing 1/07 at 1730 revealed, " n. At this point to keep other rapped my arms around him across his right shoulder fit arm and locked my hands to get him to the floor so I on till help comes that will at Staff came from all ab body parts arms, legs etc. his head and started pulling to the floor. When I felt the efloor I quickly loosened my front of him because he on his back. Still with or pt's right side of face was was fighting very hard and ng so hard to turn his head eyes turned blood red and the going to pop out. Pt was taff at this pointwhen pt essive attempt to get up and the passed out so we slowly bint RN's checking out Pt and called Code Blue	A	204			

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A 204	patient down just unticould safely be walked such as a seclusion or manually carry the patton a seclusion or restrict revealed there are secreadily available on the treatment mall (the dathere were no seclusid dining room. Interviet the patient to the clost room, which would have had to cat doors, 2 of which were carrying the patient to because of his larges with which he was fig revealed another nurs an order for a PRN manually restrain the unresponsive. Interviplan or process in plan physically combative to a seclusion or restrict Nine staff members the involved in the manual the dining room on 02 08/01/07 between 13 B, Staff C, Staff D, Stand Staff N). Intervier revealed the patient with the floor with staff members with the floor with the flo	ocess would be to hold the I he either calmed down and ad to a safe environment, or restraint room, or to atient (if he is still combative) raint room. Interview clusion and restraint rooms he patient wards and in the ay area). Interview revealed on or restraint rooms in the we revealed in order to carry rest seclusion or restraint rooms in the were seen on Ward 6, they rry him through 3 sets of relocked. Interview revealed of Ward 6 was not feasible size and the amount of force thing the staff. Interview recalled the physician to get redication to help calm the realed the staff continued to patient until he became rewevealed there was no rece for the transport of a patient from the dining room raint room. That witnessed and/or were all restraint of Patient #2 in 2/01/07 were interviewed on 30 and 1900 (Staff A, Staff aff E, Staff F, Staff H, Staff I w with all 9 staff members was manually restrained on embers holding all 4 reviews revealed a staff ed on top of the patient	A	204			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 204	Nine direct patient ca and nursing assistant 08/01/07 between 13 B, Staff C, Staff D, St Staff N). 8 of the 9 st revealed there was n available at the hospi a patient on the floor. interviewed revealed techniques for emerginterventions. Interviewed revealed techniques do not increstraints on a patien floor. Medical record reviewevidence of an Emergintervention (ERI) Prostatus monitoring, or assessment (includin for respiratory/cardiate implementation of Administrative staff in revealed there was no available at the hospi a patient on the floor. NCI techniques do no restraints on a patien floor. Interview revealment of the incidical occupant occupa	re staff members (nurses is) were interviewed on 30 and 1900 (Staff A, Staff aff F, Staff I, Staff K and itself members interviewed of policy or procedure tal for the manual restraint of All of the staff members the hospital uses NCI ency restrictive ews revealed the NCI elude the use of manual trafter the patient is on the vice revealed no documented gency Restrictive express Note, including health of a health status grobservations/assessments and distress) by a nurse during of the manual restraint.	A 204				

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	0		1	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655	1 08/0.	2/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 204	him because of his si violence". Interview of or process for the tracombative patient fro seclusion or restraint there was no docume status assessment (in observations/assessidistress) by a nurse of the manual restraint. There was no docume Progress Note or of the manual restraint. 482.13(e)(4)(ii) PATII OR SECLUSION The use of restraint of implemented in accordappropriate restraint determined by hospit State law. This STANDARD is Based on hospital por reviews, closed medi investigative report rehospital failed to have the safe and appropripatient on the floor. The findings include: Review of hospital por Restrictive Intervention revealed, "Policy: Is manual restraint and/appropriate restraint and/appropria	al restraint "couldn't carry ze and the amount of confirmed there was no plan insport of a physically in the dining room to a room. Interview confirmed contation available of a health including ments for respiratory/cardiac during the implementation of Interview also confirmed contation available of an ERI inealth status monitoring for ENT RIGHTS: RESTRAINT or seclusion must be redance with safe and and seclusion techniques as all policy in accordance with not met as evidenced by: licy and training manual cal record reviews, hospital's eview and staff interviews the evaluation and a seclusion of a solicy entitled, "Emergency		814			8/10/07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 814	when substantial propossible, verbal or en non-physical techniquintervention in the material provision is made for conditions in areas use mergency Restrictive use must be ordered on the incident report (Man. R) The holding emergency for any lewhich restricts the paramovement. 1. Holding patient in an approve or other manner that movements constitute patient This include that are approved No (NCI) techniques during who are NCI-certified restraint for any extensanctioned "Review documentation of instruction of instruction in the use as well as therapeutic techniques. Review of instructions for the on the floor.	which a patient is in njury to self or others or perty damage is occurring. If extronomental change (i.e. uses) is the preferred anagement of behavior. In humane, secure, and safe sed Definitions/Guidelines: the Interventions: (Note: Any by a physician and reported form.) Manual Restraint of a patient in an another of time in a manner tient's freedom of any a physically resistive double the apeutic hold/carry/walk restricts his or her the sesting an emergency, by staff and the priod of time is not any revealed no tructions for the manual content of the surrounding an emergency. In the immediate goal of the intention is to insure the safety see in the surrounding area." NCI program provides of non-physical techniques	A	814			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 814	schizophrenia. Recopatient was manually dining room by 7 star approximately 1210. approximately 1215 was not breathing an review resuscitative initiated and the paticacute care hospital and he subsequently was Nine staff members involved in the manual the dining room on 008/01/07 between 13 B, Staff C, Staff D, S and Staff N). Interview revealed the patient the floor with staff mextremities. All 9 into member was position diagonally across the linear lateral on 08/01/07 manual restraint of P dining room on 02/07 RN present) "were the patient". In process would be to until he either calmed walked to a safe envisedusion or restraint the patient (if he is stor restraint room. In seclusion and restrait the patient wards and	on 01/01/07 for paranoid ord review revealed the restrained on the floor of the floor floor of the twas noted that the patient dhad no pulse. Record efforts were immediately ent was transferred to an tapproximately 1235, where is pronounced dead. That witnessed and/or were all restraint of Patient #2 in 2/01/07 were interviewed on 30 and 1900 (Staff A, Staff taff E, Staff F, Staff H, Staff I ew with all 9 staff members was manually restrained on embers holding all 4 erviews revealed a staff ned on top of the patient expatient's chest. C (a RN present at the floor of the atient #2 on the floor of the atient #2 on the floor of the other ying to figure out how to otherview revealed the usual hold the patient down just didown and could safely be	A 8	14			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 814	Interview revealed in the closest seclusion would have been on to carry him through 3 were locked. Intervie patient to Ward 6 was large size and the amwas fighting the staff. nurse called the phys PRN medication to he Interview revealed the restrain the patient ur Interview revealed the in place for the transprombative patient from seclusion or restraint. Nine direct patient ca and nursing assistant 08/01/07 between 13 B, Staff C, Staff D, St Staff N). 8 of the 9 st revealed there was not available at the hospi a patient on the floor. Interviewed revealed techniques for emerginterventions. Interviewed restraints on a patient floor.	rooms in the dining room. order to carry the patient to or restraint room, which Ward 6, they would have had 3 sets of doors, 2 of which w revealed carrying the s not feasible because of his rount of force with which he Interview revealed another ician to get an order for a elp calm the patient. e staff continued to manually ntil he became unresponsive. ere was no plan or process roort of a physically m the dining room to a room. re staff members (nurses s) were interviewed on 30 and 1900 (Staff A, Staff aff F, Staff I, Staff K and aff members interviewed to policy or procedure tal for the manual restraint of All of the staff members the hospital uses NCI ency restrictive ews revealed the NCI llude the use of manual t after the patient is on the	A	814			
	revealed there was no available at the hospi a patient on the floor. hospital uses NCI tec	terview on 08/02/07 at 0845 o policy or procedure tal for the manual restraint of Interview revealed the hniques for emergency ns. Interview confirmed the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	344002		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	08/0	2/2007
BROUGH	TON HOSP				000 S STERLING ST ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIEM OF THE APPROPRIEM OF	D BE	(X5) COMPLETION DATE
A 814	restraints on a patient floor. Interview reveal "never thought in term this" prior to the incide 02/01/07. Interview retransporting the patie during the manual reshave been to move his or restraint room. Into involved in the manual him because of his six violence". Interview or process for the transcombative patient from seclusion or restraint 482.13(e)(10) PATIEN OR SECLUSION The condition of the psecluded must be molicensed independent that have completed in paragraph (f) of this determined by hospital the hospital staff faile the hospital staff faile the health status of a manual restraints revious the process include:	at include the use of manual that after the patient is on the alled administrative staff had as of we have no practice for ent with Patient #2 on evealed the process of ant in his combative state straint on 02/01/07 should im to Ward 6 to a seclusion erview revealed the staff all restraint "couldn't carry are and the amount of confirmed there was no plan ansport of a physically me the dining room to a room. NT RIGHTS: RESTRAINT The training criteria specified is section at an interval all policy. The training criteria specified is section at an interval all policy. The training criteria specified is section at an interval all policy. The training criteria specified is section at an interval all policy. The training criteria specified is section at an interval all policy. The training criteria specified is section at an interval all policy.		814			8/10/07

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
A 822	Restrictive Intervention revealed, "Patients and during use of all emerinterventions. Compare periodic reviews of the are provided to new conditions of continue employmentDefinit Restrictive Intervention be ordered by a physicident report form.). The holding of a patiel length of time in a mapatient's freedom of an apatient's freedom of an apatient's freedom of a physically resistive patherapeutic hold/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more restraint for that patient therapeutic holds/carry restricts his or her more res	ons" dated 08/30/06 re continuously observed rgency restrictive etency-based training and e use of these procedures clinical staff and are ed ions/Guidelines: Emergency ons: (Note: Any use must ician and reported on theManual Restraint (Man. R) ent in an emergency for any inner which restricts the novement. 1. Holding a atient in an approved r/walk or other manner that ovements constitutes manual intThis includes ries that are approved North (NCI) techniques during an who are NCI-certified. The int for any extended period of id. 2. When Man. R is health status (adequate eysical distress) is assessed in and is documented on the tell Intervention Progress on of Emergency Restrictive in Responsibility: 1. As soon a health status assessment observing/assessing for stress (clinical assessment observing/assessing for stress (clinical assessment observing/assessing for stress (clinical assessment	A	822			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	344002	100	ET ADDRESS, CITY, STATE, ZIP CODE 0 S STERLING ST PRGANTON, NC 28655		02/2007
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		(X5) COMPLETION DATE
A 822	Review of "North Cardated 03/31/03 revearemember that the imprestrictive intervention the person and those Once the person is reshould insure that the intervention. They are apparent circulation patient was admitted schizophrenia and die the physician's dischizophrenia and intervention in the care The was characterized by including inappropria Dover the course of (Patient's name) show the stopped making sand became much mis own personal self the was still, even on death, very disorgani questions with nonse able to sit still, which was able to respond appropriately, which his hygiene showed g Throughout his stanot have any great please of the dining room at	olina Intervention" manual aled, "It is important to imediate goal of the in is to insure the safety of in the surrounding area. Estrained, staff involved a person is safe within the ele breathing freely, no problems" If yo of Patient #2 revealed the on 01/01/07 for paranoid and on 02/01/07. Review of arge summary dated Patient's name) was chotic with a long history of a first part of his stay here behavioral volatility, the and bizarre behavior on Zyprexa (an altion) on or about 1/18/07 the next twelve days, wed significant improvement. The or many bizarre statements one engaged with regards to be care and personal hygiene. Interview, the day before his zed and answered many quiturs. However, he was was markedly improved and gross improvement y, (Patient's name) really did hysical complaints arme abruptly agitated while lunch (on the date of his to be looking for more food,	A 822			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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A 822	especially lately, had general. This time, fous, he became intensionand began to throw to harm to peers and to manually restrained a restraint, he apparent cardiac event and de the scene, as well as expired" Medical record review M (a registered nurse 1300 (denoted as "lata approximately 1210 pwas placed in MR (mstaff, I then assisted (Staff I) and (Staff J) were holding pt's L (lata approximately 1211. was still combative. RN and (Staff F) LPN arrived to assist, at a became unresponsive Review revealed no estatus assessment, in observations/assessing distress by Staff M, the Emergency Restrictive restraint). Medical record review C (a RN) dated 02/01 "late entry") revealed dining room patient in was 1210. Patient in	st, he typically was st a few staff members and been more redirectable in or reasons still unknown to sely irate, intensely agitated, ashcans around, threatening staff. Subsequently, he was and in the context of that sty suffered some kind of spite provision of CPR on rapid response of EMS, he of documentation by Staff standard response of EMS, he are entry") revealed, ""at set threw trash can at staff. Pt anual restraint) resisting (Staff A), (Staff L), (Staff D), with MR. (Staff J) and I set leg. ET was alerted at (Staff N) RN arrived. Pt Approximately 1212 (Staff C) (Iicensed practical nurse) oproximately 1215 pt se. (Staff N) called code"	A 822				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	ED
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A 822	continued fighting and member (Staff A) who (Staff A) was repeated on him in which his re (Staff N) attempted to possible PRN (as need Patient continued to food (with) no acute physicial back @ manual restrictions and the patient and At 1215 patient non restimulation. (Staff N) to get back from patient or pulse present. Stathis writer's request and documentation of a hincluding observation respiratory/cardiac diemergency Restrictive restraint). Medical record reviewed evidence of an Emerginatery ention (ERI) Prostatus monitoring, or assessment (including for respiratory/cardiac the implementation of a health status assobservations/assessing distress) by a nurse of the manual restraint. There was no documentation of the manual restraint.	tion during manual restraint d attempting to bite staff of was straddling patient. It was straddling patient of call distress. It was straint of call distress. It was to the distress. It was to the distress. It was to the distress writer was to the distress of call distress. It was to the distress of call distress of c	A	822			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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A 835	The patient has the rof restraint or seclusion. This STANDARD is Based on hospital poreviews, closed medianvestigative report rehospital failed to implete chniques for 1 of 2 reviewed (#2). The findings include: Review of hospital poreviewed (#2). The findings include: Review of hospital poreviewed (#2). The findings include: Review of hospital poreviewed, "Policy: Is manual restraint and used only on an emelohavior or action in imminent danger of it when substantial propossible, verbal or ernon-physical techniquintervention in the material propossible, verbal or ernon-physical techniquintervention in the m	not met as evidenced by: licy and training manual cal record reviews, hospital's eview and staff interviews the ement safe restraint patients in manual restraints blicy entitled, "Emergency ons" dated 08/30/06 olation time-out, seclusion, or psychiatric restraint are regency basis to terminate a which a patient is in njury to self or others or overty damage is occurring. If evironmental change (i.e. ues) is the preferred anagement of behavior. humane, secure, and safe sedDefinitions/Guidelines: the Interventions: (Note: Any by a physician and reported form.)Manual Restraint of a patient in an nigth of time in a manner tient's freedom of ting a physically resistive d therapeutic hold/carry/walk	A 835			8/10/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 835	that are approved No (NCI) techniques dur who are NCI-certified restraint for any exters anctioned" Review documentation of ins restraint of a patient of the restrictive interverse of the person and the Review revealed the instruction in the use as well as therapeutic techniques. Review of instructions for the on the floor. Medical record review patient was admitted schizophrenia and die the physician's discharacterized by including inappropriapatient was initiated antipsychotic medicaOver the course of (Patient's name) show the stopped making sand became much much must be stopped making sand became much much must be stopped making sand became much much must be stopped making sand became much must be stopped must be sto	rth Carolina Intervention ing an emergency, by staff . The use of manual inded period of time is not w revealed no tructions for the manual on the floor. colina Intervention" manual inded, "the immediate goal of intion is to insure the safety ise in the surrounding area." NCI program provides of non-physical techniques of holds and transport revealed no documentation manual restraint of a patient ov of Patient #2 revealed the on 01/01/07 for paranoid ed on 02/01/07. Review of arge summary dated Patient's name) was chotic with a long history of the first part of his stay here behavioral volatility, the and bizarre behavior d on Zyprexa (an tion) on or about 1/18/07	A 835			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		,2,2,001	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 835	his hygiene showed ofThroughout his star not have any great phy (Patient's name) because in the dining room at death). He appeared which he had done be redirection. In the paredirectable by at least especially lately, had general. This time, fous, he became intensionand began to throw the harm to peers and to manually restrained a restraint, he apparent cardiac event and death escene, as well as expired" Medical record review B (a nursing assistant (denoted as "late entresid" He was still hunged the was effective @ that table to sit down, he sof mayo. Pt. said 'I are took mayo from the prook food out of trash Pt. was redirected interfollowing pt. Pt. turner another trashcan. Me (Emergency Transmisgrabbed pt. then staff	at least at times was markedly improved and gross improvement y, (Patient's name) really did hysical complaints ame abruptly agitated while lunch (on the date of his to be looking for more food, efore and refused st, he typically was st a few staff members and been more redirectable in or reasons still unknown to sely irate, intensely agitated, hashcans around, threatening staff. Subsequently, he was and in the context of that tily suffered some kind of spite provision of CPR on rapid response of EMS, he of documentation by Staff th dated 02/01/07 at 1307 hy") revealed, "pt. (patient) gry'; after eating his lunch. hore food from the ladies that window. Pt was redirected, it time. Pt. started going to his stopped and got five packs m going to eat them' staff t.; pt. then walked around, can and started eating it.	A 83	5			

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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A 835	got first aid kit such a for CPR." Medical record review L (a nursing assistant (denoted as "late entit Staff L) walked in, from Everything was ok as by. As ptstood up mayonnaise I and (Staff and the grabbed his hands are up started digging in food. Pt. was very are can and threw it toware (Staff A), grabbed pt help. We finally got pt fighting to get up, pt so a staff member can stared CPR. I held the arm, (Staff A) on top. could not see pts face assistant) arms or has medical record review (a nursing assistant) (denoted as "late entiticame in and took him top of (Patient's name name)'s right arm hol on the right leg. (Sta L) had his left arm how was violently strugglii	d 2121 Code Blue other staff is O2 (oxygen) tank and all ov of documentation by Staff it) dated 02/01/07 at 1330 ry") revealed, "I (name of m lunch @ 1200. I usual a few minutes went and grabbed 4 pack of raff B) asked pt to give us the and them over so we not took them away. Pt. got the trash for mayo or other nary. Pt. picked up the trash ras other staff approached to be on the ground. Pt. was still angry. After a few on have calmed down so we toward the code while (Staff F) ne left arm, (Staff I) held right the leg, (Staff D) held left leg, (Staff A)'s back facing me er or the CNA (nursing)	A 835				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
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NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP	10	EET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST ORGANTON, NC 28655	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 835 Continued From page 27 nurse asked someone to call 2121 (Code Blue). The medical team came in. Then I was asked to get up and return to my ward." Medical record review of documentation by Staff M (a registered nurse, RN) dated 02/01/07 at 1300 (denoted as "late entry") revealed, ""at approximately 1210 pt threw trash can at staff. Pt was placed in MR (manual restraint) resisting staff, I then assisted (Staff A), (Staff L), (Staff D), (Staff I) and (Staff J) with MR. (Staff J) and I were holding pt's L (left) leg. ET was alerted at approximately 1211. (Staff N) RN arrived. Pt was still combative. Approximately 1212 (Staff C) RN and (Staff F) LPN (licensed practical nurse) arrived to assist, at approximately 1215 pt became unresponsive. (Staff N) called code" Medical record review of documentation by Staff I (a nursing assistant) dated 02/01/07 at 1310 (denoted as "late entry") revealed, "he (Patient #2) grabbed trash can and threw it at staff. At that time we grabbed pt and rolled him to the floor. I had his right legg holding it down, (Staff L) + (Staff D) had his left legg holding it and (Staff J) had his right legg holding it down, (Staff L) + (Staff D) had his left letting Pt up to take him to restraint room but Pt start kicking again. Someone asked if we could get an IM (intramuscular injection) and someone said the nurse was bring it. (Staff N) RN said she would give the shot when it came. Shot was not given. Pt went relaxed and (Staff C) RN checked and Pt took deep breaths and then stopped. (Staff F) and (Staff C) started CPR and the code team was called"	A 835			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		344002	B. WING _		1	C)2/2007	
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		72.72001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 835	C (a RN) dated 02/01 "late entry") revealed dining room patient in was 1210. Patient in of five minutes from responding to redirect continued fighting and member (Staff A) who (Staff A) was repeated on him in which his responding to redirect continued to form the patient continued to form patient continued cont	v of documentation by Staff //07 at 1330 (denoted as , "Upon entering the F1 in manual restraints, which manual restraints, duration my arrival. Patient not tion during manual restraint di attempting to bite staff of was straddling patient. It disply was 'no I'm not on him'. It is reach patient's doctor for edd medication) order. It is writer was to the di (Staff N) @ patient's head. It is writer was to the di (Staff N) @ patient's head. It is writer told (Staff A) ent. No respirations present enter the ereport by Staff N (a RN) as revealed, "1212 I walked the ereport by Staff N (a RN) as	A 838	5			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			(X3) DATE SUR COMPLETE	
		344002	B. WIN	1G _		08/02	2/ 2007
	ROVIDER OR SUPPLIER		'		REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 835	breathing. 2 or 3 of under the property revealed documents by Staff N dated 02/0 "late entry"). Review Staff N revealed, "He team) called to (F1) of Upon arrival 2 RN's at Hold. RN's stated pt. Out of the dining room operator. Pt. was grostaff. Requested opename) ASAP to (F1) Walked back to pt. as closed and tounge was blueish tint. Instructed Attempted to obtain rebreath sounds. None Review of documentate hospital's investigative assistant) dated 02/0 (patient) threw the capts and staff safe I will from behind. One are the other under his lein front. I was unable thought if I just hange least slow him down, directions trying to grosmeone got hold of down to get him to go pt starting to go to the hold to slide around it was going to go down same hold on the flocon my right chest. Pt.	tart again'. I said no he's not as said call a code" hospital's investigative mentation of a second note 1/07 at 1706 (denoted as of the second note made by ard care team (ET response lineing room and responded. Ind CNA's had pt in NCI was too agitated to move in 1213 called hospital owling and kicking fighting erator to call (Physician's dining room or this phone. It is sessed his face eyes were as protruded slightly c (with) indicated to stop NCI. It is seponse, or pulse, and is noted began CPR" Attion available in the ite report by Staff A (a nursing 1/07 at 1730 revealed, " In At this point to keep other rapped my arms around him is a cross his right shoulder fit arm and locked my hands is to get him to the floor so I on till help comes that will at	A	835	5		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		344002	D. WIIV			08/02	2/2007
	OVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 835	looked as if they were being held by many shad a real hard aggret to bite Pt looked as if got off him. At this possible and had no response team." Medical record reviewevidence of an "Emer Intervention Progress review revealed no do physician's order for the Interview with Staff Corevealed during the monthe floor of the din and Staff M (the othe figure out how to mover ever a seclusion of the din and Staff M (the othe figure out how to mover ever a seclusion of the din and Staff M (the othe figure out how to move ever a seclusion of the din and Staff M (the othe figure out how to mover ever a seclusion of the din and Staff M (the othe figure out how to move ever a seclusion of the din and Staff M (the othe figure out how to move ever a seclusion or restricted the patient down just unticould safely be walked such as a seclusion or restricted there are secreadily available on the treatment mall (the dathere were no seclusidining room. Interviewed the patient to the closs room, which would have had to cate doors, 2 of which were carrying the patient to because of his large second to the second th	eyes turned blood red and e going to pop out. Pt was taff at this pointwhen pt essive attempt to get up and he passed out so we slowly bint RN's checking out Pt and called Code Blue If vervealed no documented regency Restrictive en Note". Further record bocumentation of a che manual restraint. If on 08/01/07 at 1600 manual restraint of Patient #2 ing room on 02/01/07 he re RN present) "were trying to be the patient". Interview occess would be to hold the land to a safe environment, or restraint room, or to entient (if he is still combative) reaint room. Interview clusion and restraint rooms in the ency area). Interview revealed on or restraint rooms in the way area). Interview revealed on or restraint rooms in the way area). Interview revealed on or restraint rooms in the way area on Ward 6, they manual restraint rooms in the way area on Ward 6, they manual restraint rooms of the locked. Interview revealed on Ward 6 was not feasible size and the amount of force	A	335	DEFICIENCY)		
	because of his large s with which he was fig						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLETE (X3) DATE SUF COMPLETE						
		344002	B. WING		08/0	C)2/2007
	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST ORGANTON, NC 28655	3000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 835	patient. Interview reversal manually restrain the unresponsive. Interviplan or process in play physically combative to a seclusion or rest. Nine staff members to involved in the manual the dining room on 00 08/01/07 between 13 B, Staff C, Staff D, Stand Staff N). Interviewere led the patient of the floor with staff meter extremities. All 9 interviewed revealed the patient of the diagonally across the line of the floor with staff of the staff N). Staff C, Staff D, Staff N). 8 of the 9 strevealed there was no available at the hospinal patient on the floor interviewed revealed techniques for emerginter extending the staff of the staff o	redication to help calm the realed the staff continued to patient until he became lew revealed there was no ace for the transport of a patient from the dining room raint room. That witnessed and/or were all restraint of Patient #2 in 2/01/07 were interviewed on 30 and 1900 (Staff A, Staff aff E, Staff F, Staff H, Staff I I I I I I I I I I I I I I I I I I	A 835			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	N	(X3) DATE SUF COMPLET	
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	ROVIDER OR SUPPLIER	044002		STREET ADDRESS, CIT 1000 S STERLING S MORGANTON, NO	ST	<u> </u> 08/0.	2/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (VIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL EFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 835	restrictive intervention NCI techniques do not restraints on a patient floor. Interview reveat "never thought in term this" prior to the incide 02/01/07. Interview representation of the patient during the manual restraint room. Into involved in the manual him because of his sitiviolence". Interview or process for the transcombative patient from seclusion or restraint 482.13(f)(1) PATIENT SECLUSION Staff must be trained competency in the appropriet in the appropriet in the appropriet in the appropriet in the actions specified. This STANDARD is a Based on hospital por record reviews, hospital failed to be a second to the second reviews, hospital failed to be a second review of the second review of the hospital failed to be a second review of the second review of the hospital failed to be a second review of the second review of the hospital failed to be a second review of the second review of the hospital failed to be a second review of the hospital fai	confirmed the amount of confirmed the amount of a physically m the dining room to a room. TRIGHTS: RESTRAINT OR Tanda dable to demonstrate plication, monitoring, viding care for a patient in before performing any of	A	337			8/10/07

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		1	2/ 2007
	COVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 837	Restrictive Intervention revealed, "Policy: Is manual restraint and/ used only on an emeripheavior or action in simminent danger of in when substantial propossible, verbal or en non-physical techniquintervention in the material Provision is made for conditions in areas use Emergency Restrictive use must be ordered on the incident report (Man. R) The holding emergency for any lewhich restricts the particular movement. 1. Holding patient in an approve or other manner that movements constituted patient This included that are approved No (NCI) techniques during who are NCI-certified restraint for any externing sanctioned" Revied documentation of instrestraint of a patient of the person and the Review of "North Cardated 03/31/03 reveat the restrictive interversion of the person and the Review revealed the	olicy entitled, "Emergency ons" dated 08/30/06 colation time-out, seclusion, or psychiatric restraint are regency basis to terminate a which a patient is in nijury to self or others or perty damage is occurring. If evironmental change (i.e. uses) is the preferred enagement of behavior. In humane, secure, and safe sedDefinitions/Guidelines: the Interventions: (Note: Any by a physician and reported form.)Manual Restraint of a patient in an another of time in a manner tient's freedom of the graph of time in a manner tient's freedom of the graph of the graph of time in the set therapeutic hold/carry/walk restricts his or her the set therapeutic holds/carries of the carries of manual the set therapeutic holds/carries of the use of manual the ded period of time is not the revealed not the floor. The use of manual the floor.	A	837			

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		344002			08	02/2007
BROUGHTON	DER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP COD 00 S STERLING ST ORGANTON, NC 28655	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
ted of in on on on the part set the part set the ozer add psy was incompanied in the part of the part	instructions for the the floor. dical record review tient was admitted nizophrenia and directions of the physician's discharge physician's discharge physician's discharge physician's care The scharacterized by chiatric the course of attent's name) showed the scharacterized physical	revealed no documentation manual restraint of a patient v of Patient #2 revealed the on 01/01/07 for paranoid ed on 02/01/07. Review of arge summary dated Patient's name) was chotic with a long history of e first part of his stay here v behavioral volatility, te and bizarre behavior d on Zyprexa (an tion) on or about 1/18/07 the next twelve days, wed significant improvement. To many bizarre statements ore engaged with regards to recare and personal hygiene. Interview, the day before his zed and answered many quiturs. However, he was was markedly improved. He at least at times was markedly improved and gross improvement y, (Patient's name) really did hysical complaints ame abruptly agitated while lunch (on the date of his	A 837			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		100	ET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST DRGANTON, NC 28655		02/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 837	manually restrained a restraint, he apparent cardiac event and de the scene, as well as expired" Medical record review B (a nursing assistant (denoted as "late ent said 'He was still hun Pt was trying to get in serve food from the wwas effective @ that table to sit down, he sof mayo. Pt. said 'I a took mayo from the ptook food out of trash Pt. was redirected into following pt. Pt. turned another trashcan. Mr. (Emergency Transmit grabbed pt. then staff tried to kick, bite staff his name. Staff called got first aid kit such a for CPR." Medical record review L (a nursing assistant (denoted as "late ent Staff L) walked in, from Everything was ok as by. As ptstood up mayonnaise I and (Si mayo pr would not had grabbed his hands and up started digging in	staff. Subsequently, he was and in the context of that thy suffered some kind of spite provision of CPR on rapid response of EMS, he of documentation by Staff thy dated 02/01/07 at 1307 ray") revealed, "pt. (patient) gry'; after eating his lunch. The food from the ladies that window. Pt was redirected, it time. Pt. started going to his stopped and got five packs in going to eat them' staff the trip. The walked around, can and started eating it. The effective staff stopped editation was called and ET sesion) button was hit. Staff for lowered pt. to ground pt. The form the ladies that window. Pt. was not responding to decide the decident of the staff stopped editation was called and ET sesion) button was hit. Staff for lowered pt. to ground pt. The was not responding to decide the staff stopped that and all word documentation by Staff the dated 02/01/07 at 1330 ray") revealed, "I (name of me lunch @ 1200. It is usual a few minutes went and grabbed 4 pack of that and grabbed 4 pack	A 837			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		344002	B. WIN	IG _		C 	
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP			!		REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655	00/02	2/2007
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 837	(Staff A), grabbed pt help. We finally got pt fighting to get up, pt s minutes pt seemed to gradually let go but p so a staff member ca stared CPR. I held tram, (Staff J) held rig and (Staff A) on top. could not see pts face assistant) arms or ha Medical record review (a nursing assistant) (denoted as "late enticame in and took him top of (Patient's name name)'s face at all. I name)'s right arm hol on the right leg. (Star L) had his left arm howas violently strugglin After several minutes nurse asked someon. The medical team ca get up and return to remedical record review M (a registered nurse 1300 (denoted as "late approximately 1210 pwas placed in MR (m staff, I then assisted (Staff I) and (Staff J) were holding pt's L (late approximately 1211. was still combative.	rds staff. A staff member as other staff approached to at on the ground. Pt. was still angry. After a few have calmed down so we wasn't moving or breathing led the code while (Staff F) are left arm, (Staff I) held right his leg, (Staff D) held left leg, (Staff A)'s back facing me are or the CNA (nursing ands." I of documentation by Staff J dated 02/01/07 at 1345 by") revealed, "(Staff A) on and a leg (Staff I) on (Patient's adding it. (Staff M) and I were aff B) was on the left. (Staff Idding it. (Patient's name) are to call 2121 (Code Blue). Then I was asked to	A	837			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	344002 B. WING			C s/ 02/2007		
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP			10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST IORGANTON, NC 28655		2/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
A 837	Medical record review (a nursing assistant) (denoted as "late entithe" (staff D) had his right at the (Staff D) had his left had his right legg hold laying across left side across his back. We him to restraint room Someone asked if we (intramuscular injection nurse was bring it. (Sigive the shot when it Pt went relaxed and (and breathing. (Staff deep breaths and the (Staff C) started CPR called"	pproximately 1215 pt e. (Staff N) called code" v of documentation by Staff I dated 02/01/07 at 1310 ry") revealed, "he (Patient n and threw it at staff. At pt and rolled him to the arm holding it down, (Staff L) it legg holding it and (Staff J) ding it down. (Staff A) was e of Pt chest with his left arm tried letting Pt up to take but Pt start kicking again.	A 837			
	C (a RN) dated 02/01 "late entry") revealed dining room patient in was 1210. Patient in of five minutes from r responding to redirect continued fighting and member (Staff A) who (Staff A) was repeate on him in which his re (Staff N) attempted to possible PRN (as nee Patient continued to f	/07 at 1330 (denoted as , "Upon entering the F1 n manual restraints, which manual restraints, duration ny arrival. Patient not tion during manual restraint d attempting to bite staff o was straddling patient. dly asked if he had weight eply was 'no I'm not on him'. o reach patient's doctor for eded medication) order. fight the manual restraint c cal distress. (Staff N) arrived				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING			
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP		10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST ORGANTON, NC 28655	, 35.	52,2001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 837	side of the patient an At 1215 patient non r stimulation. (Staff N) to get back from patie or pulse present. Stathis writer's request Review of documentathospital's investigative dated 02/01/07 at 133 into dining room p (af Staff had the pt. in the and growling at staff. to the kitchen and cal (Physician's Name) a had stated that the newalked to the patient' concerned his eyes we protruded slightly c (v same time that (Staff hand on his (pts.) new told him not to do that said twice. Some state background 'he will sibreathing. 2 or 3 of use Further review of the report revealed documents of the dining room operator. Pt. was grosstaff. Requested open name) ASAP to (F1)	aint. This writer was to the d (Staff N) @ patient's head. esponsive to verbal or tactile and this writer told (Staff A) ent. No respirations present off member called 2121 @" ation available in the ereport by Staff N (a RN) as revealed, "1212 I walked ofter) care team was called. e floor. He was screaming I walked to the door going alled for the operator to page to 1213. I walked back staff curses were out side. It is face and became were closed and his tounge with) blue tint. I note at the A's name) had his R (right) ck Firmly and took his hand to 'get off his chest' I	A 837			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING			
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP		10	EET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST ORGANTON, NC 28655		02/2001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 837	blueish tint. Instructed Attempted to obtain in breath sounds. None Review of documentate hospital's investigative assistant) dated 02/0 (patient) threw the capts and staff safe I will from behind. One arithe other under his lein front. I was unable thought if I just hang least slow him down. directions trying to great Someone got hold of down to get him to go pt starting to go to the hold to slide around it was going to go down same hold on the floo on my right chest. Put at same time was trying and bite me that his eloked as if they were being held by many shad a real hard aggreate to bite Pt looked as if got off him. At this pound had no response team."	as protruded slightly c (with) and staff to stop NCI. esponse, or pulse, and a noted began CPR" ation available in the ele report by Staff A (a nursing 1/07 at 1730 revealed, " In. At this point to keep other rapped my arms around him an across his right shoulder fit arm and locked my hands at to get him to the floor so I con till help comes that will at Staff came from all ab body parts arms, legs etc. his head and started pulling to the floor. When I felt the eleftoor I quickly loosened my in front of him because he in on his back. Still with or pt's right side of face was a was fighting very hard and and seyes turned blood red and elegoing to pop out. Pt was staff at this pointwhen pt essive attempt to get up and the passed out so we slowly bint RN's checking out Pt and called Code Blue of revealed no documented regency Restrictive is Note". Further record ocumentation of a	A 837			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/20/2007 FORM APPROVED

A 837 Continued From page 40 Interview with Staff C on 08/01/07 at 1600 revealed during the manual restraint of Patient #2 on the floor of the dining room on 02/01/07 he and Staff M (the other RN present) "were trying to figure out how to move the patient". Interview revealed the usual process would be to hold the patient down just until he either calmed down and could safely be walked to a safe environment, such as a seclusion or restraint room, or to manually carry the patient (if he is still combative) to a seclusion or restraint room. Interview revealed there are seclusion and restraint rooms readily available on the patient wards and in the treatment mall (the day area). Interview revealed there were no seclusion or restraint room, which would have been on Ward 6, they would have had to carry him through 3 sets of doors, 2 of which were locked. Interview revealed carrying the patient to Ward 6 was not feasible because of his large size and the amount of force with which he was fighting the staff. Interview revealed another nurse called the physician to get an order for a PRN medication to help calm the patient. Interview revealed there was no	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC). <u>0938-0391</u>
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP SUMMARY STATEMENT OF DEFICIENCIES (100 S STERLING ST MORGANTON, NC 28655) MORGANTON, NC 28655 SUMMARY STATEMENT OF DEFICIENCIES (100 S STERLING ST MORGANTON, NC 28655) (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 837 Continued From page 40 Interview with Staff C on 08/01/07 at 1600 revealed during the manual restraint of Patient #2 on the floor of the dining room on 02/01/07 he and Staff M (the other RN present) "were trying to figure out how to move the patient". Interview revealed there are seclusion and restraint rooms readily available on the patient wards and in the treatment mall (the day area). Interview revealed there were no seclusion or restraint rooms readily available on the patient would have been on Ward 6, they would have had to carry him through 3 sets of doors, 2 of which were locked. Interview revealed carrying the patient to Ward 6 was not feasible because of his large size and the amount of force with which he was fighting the staff. Interview revealed an order for a PRN medication to help caim the patient. Interview revealed the patient unit to be patient to the patient to help caim the patient. Interview revealed there was no vecaled there was no service was not patient. Interview revealed the patient unit he became unresponsive. Interview revealed there was no			1 ` '					
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plan or process in place for the transport of a physically combative patient from the dining room to a seclusion or restraint room. Five of 5 personnel files reviewed (of nursing assistants and nurses) involved in the manual restraint of Patient #2 on 02/01/07 revealed no documentation of training for a procedure of manually restraining a patient on the floor.	A 837	Interview with Staff C revealed during the mon the floor of the din and Staff M (the other figure out how to move revealed the usual prepatient down just unticould safely be walked such as a seclusion of manually carry the pattern of a seclusion or restricted there are severeadily available on the treatment mall (the dathere were no seclusing room. Interview the patient to the close room, which would have had to cate doors, 2 of which were carrying the patient to because of his larged with which he was figure revealed another nursan order for a PRN meanually restrain the unresponsive. Interview revealed another nursan order for a process in playing the patient. Interview revealed another nursan order for a PRN meanually restrain the unresponsive. Interview revealed another nursan order for a process in playing the patient. Interview revealed another nursan order for a PRN meanually restrain the unresponsive. Interview revealed another nursan order for a process in playing the patient. Interview revealed another nursan order for a process in playing the patient of patient assistants and nurses restraint of Patient #2 documentation of train	con 08/01/07 at 1600 nanual restraint of Patient #2 ing room on 02/01/07 he r RN present) "were trying to ve the patient". Interview ocess would be to hold the I he either calmed down and ed to a safe environment, or restraint room, or to attent (if he is still combative) raint room. Interview clusion and restraint rooms ne patient wards and in the ay area). Interview revealed ion or restraint rooms in the w revealed in order to carry sest seclusion or restraint ave been on Ward 6, they arry him through 3 sets of re locked. Interview revealed by Ward 6 was not feasible size and the amount of force thing the staff. Interview se called the physician to get redication to help calm the realed the staff continued to patient until he became item revealed there was no rece for the transport of a patient from the dining room raint room. Res reviewed (of nursing s) involved in the manual c on 02/01/07 revealed no ning for a procedure of	A	837			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP			1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST 00RGANTON, NC 28655		2/2007
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A 837	involved in the manual the dining room on 02 08/01/07 between 13 B, Staff C, Staff D, Stand Staff N). Intervier revealed the patient of the floor with staff me extremities. All 9 intermember was position diagonally across the Nine direct patient call and nursing assistant 08/01/07 between 13 B, Staff C, Staff D, Staff N). 8 of the 9 strevealed there was no available at the hosping a patient on the floor interviewed revealed techniques for emerginterventions. Interviewed not incomplete the control of the staff of the sta	al restraint of Patient #2 in 2/01/07 were interviewed on 30 and 1900 (Staff A, Staff aff E, Staff F, Staff H, Staff I w with all 9 staff members was manually restrained on embers holding all 4 erviews revealed a staff led on top of the patient patient's chest. The staff members (nurses is) were interviewed on 30 and 1900 (Staff A, Staff aff F, Staff I, Staff K and itself members interviewed on policy or procedure tal for the manual restraint of All of the staff members the hospital uses NCI	A 837			
	revealed there was n available at the hospi a patient on the floor. hospital uses NCI tecrestrictive intervention NCI techniques do no restraints on a patien floor. Interview reveal "never thought in territhis" prior to the incid 02/01/07. Interview reveal	o policy or procedure tal for the manual restraint of Interview revealed the chniques for emergency ns. Interview confirmed the ot include the use of manual t after the patient is on the alled administrative staff had ns of we have no practice for ent with Patient #2 on evealed the process of nt in his combative state				

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A 837	during the manual res have been to move h or restraint room. Into involved in the manual him because of his si- violence". Interview of or process for the train	straint on 02/01/07 should im to Ward 6 to a seclusion erview revealed the staff al restraint "couldn't carry ze and the amount of confirmed there was no plan insport of a physically m the dining room to a	A	837			